DELAWARE STATE MEDICAL JOURNAL

Issued Monthly Under the Supervision of the Publication Committee
Owned and Published by the Medical Society of Delaware

VOLUME 20
NUMBER 5

MAY, 1948

Per Copy, 50c
Per Year, $4.00

AN APPROACH TO THE PROBLEM OF ALCOHOLISM*

C. NELSON DAVIS, M. D.,**

Philadelphia, Pa.

DR. GEORGE H. GEHRMANN:[1] Mr. President and Members of the Society: I am not here to give Dr. Nelson Davis' talk, but I would like to make just a few preliminary remarks before introducing him.

Alcoholism is, always has been, and always will be a universal and worldwide problem. It is estimated that eight per cent of the population are alcoholics. By that I mean they have reached the stage where their alcohol interferred with their home life, their social life and their business life.

In my association with industry in 33 years, I have had the opportunity of seeing numerous cases of alcoholism. Taking into consideration that we have had supervision of up to 200,000 people, there would be quite a number of alcoholics in the group.

I wish to make it clear, in view of a remark made by a lady in town to me the other day, who said, "I understand you have so many drunks in the Du Pont Company you have to have Alcoholics Anonymous." And I said, "We have drunks in the Du Pont Company, yes, but we don't have any more in the Du Pont Company than you have in any other group of people, including the population of Wilmington."

For many years I struggled with the problem of the alcoholic. I saw all the money it cost industry, the individual, and the community. My struggles to convert or to cure them were not very successful. About five years ago I interested myself in AA. From that point on I commenced to learn something about the problem of alcoholism.

Time doesn't permit that I tell you all of the things I have learned. Suffice it to say that with the introduction of AA to our Company and into this community there has been astonishing success. We have here in town an active group consisting of as fine a group of people as you will meet anywhere, who have been cured or arrested—their diseased condition has been arrested, let's put it that way—because I have learned to recognize the alcoholic as one who is suffering from a disease, not just as an ordinary cantankerous individual who insists upon drinking because he is stubborn. We have seen a lot of people made happy and useful citizens.

Dr. Davis has very kindly consented to come down to talk to you today on his experiences with the problem of alcoholism.

Dr. Davis is, in addition to what President Bird has told you in the printed program, a visiting psychiatrist for the Philadelphia General Hospital, Presbyterian Hospital and the Baby's Hospital. He has held a commission in the Navy since 1936, during which time he has practiced psychiatry. So without further ado, I am going to turn the meeting over to Dr. Davis. We have brought along with us some clinical material. It is unfortunate we don't have time to present others, but we have one case which I will present later.

Thank you very much, Dr. Gehrmann. Mr. Chairman and Members of the State Medical Society: It is a pleasure to come here to speak to you and invite your attention to some of the work that we are doing.

The magnitude of the alcoholic problem needs no emphasis. We are all aware of it. What can we do about it? I will go back some sixteen years ago in my medical training and portray for you the attitude of medicine. My former Chief of the Prison System in Philadelphia is a big man with a bigger heart, and having this big heart he had sympathy for Drunk Row. After years of toiling with them he said, "They are hopeless. They are no good. They are moral cowards. They are weaklings. Kid, the only thing we can do is lock the door and throw the key away."

Well, that is a pretty tough sentence to pass on any one. A psychiatrist whom I have admired for years and under whom I served at one time, said, "They are hopeless. We can't do anything with them." In those years at Philadelphia General we had a drunk ward. They were in and out, in and out.

Medicine has always been able to sober the alcoholic, but as they left the hospital we put them into a vacuum where they consistently repeated their pattern.

This morning I have asked one of the men to take three or four minutes and portray for you what is no more than a clinical history.

Mr. Chairman and Members of the medical profession: You medical men have guinea pigs, horses, steers and etc., to experiment with. Well, I am the guinea pig of AA.

I am very glad to be here and I am glad that I am sober, a thing to which a lot of you have probably never given a thought this morning. But to an alcoholic it means everything, and I am very happy that I am a member of the Alcoholics Anonymous.

I have three minutes in which to tell you what happened in thirty years. I started drinking in 1916 and drank for thirty years. The first ten years, I would say, was sociable drinking, the second ten was getting a little serious, and the last ten my life became unbearable because of alcohol. I went to several sanatoriums. I think the differ-

[1]Medical Director, E. I. du Pont de Nemours & Company.

*Read before the Medical Society of Delaware, Wilmington, October 15, 1947.

**Physician in Charge, Saul Foundation, and Director of Research on Alcoholism, St. Luke's and Children's Hospitals.

ence is $50 a week between sanatoriums and sanitariums, and I came home to no avail.

To show you what a pattern an alcoholic can get in, I will give you an example of my daily routine from the store. The store closed at 5:30. I would leave the store twenty minutes after five, walk up 6th and King Streets or 7th and King and buy a fifth of whiskey, walk down to 7th and Shipley, walk in a bar—the bartender knew I would be coming at that time—I would have three double shots in a hurry and be right on time at 5:30 to meet my neighbor with whom I drove home.

Then when I got home I didn't go in the house. I went in the garage to collect the eggs and count the eggs or something, and I would have three or four more, and then I would go up in the house and if my wife was upstairs I would have three or four more drinks downstairs, or vice versa. That can go on for so long. So finally it became too bad. When our last child was born—it was a girl, of course—that called for a celebration. I went in the first night. I was under the influence. As a matter of fact, when I was leaving I shook hands with my mother-in-law and kissed the nurse's aide goodbye. So something had to be done. I like a person who is simple and to the point. So I went to Dr. Paul Smith. I was simple I guess, and he was to the point. He said: "Sumner, you can do one of two things." I said: "Thanks, what is it?" He said: "Either keep on drinking the way you always did—and you will last three months. Either that, or cut it out." It sounded like good advice.

By the way, when you doctors have any alcoholics that you know are going to visit you, you want to be on the alert, because we are the biggest bunch of liars. We have things figured out way before we even go to you folks.

So Paul said to me: "Sumner, how about going out to the State Hispital?" I said: "Oh, oh, here it comes. That is the end of everything—the booby-hatch."

Well, I want to tell you right now I went to the State Hospital and thank God I did. I went out there. It is a shame lots of times the stigma that is attached to the Farnhurst Hospital. One reason is that it is too close to home. If it had a fancy name and was up on the main line I think people would flock up there. I went there and stayed about two months. I came out and I made up my mind I wasn't going to take a drink. I thought I made my mind up, but I hadn't. I slipped, and I went back for a post-graduate course, and with their help, while I was there, I came into town to the Alcoholics Anonymous meetings. I was allowed to come into town and this time I really meant it.

And I think for an alcoholic the biggest thing he has to admit is that he is powerless over alcohol. There is no sense of trying to switch to beer, wine, or anything else, because it can't be done. I know, one drink and I am through—because one drink does not do any good. An alcoholic drinks to feel the effect of it.

So I came into Alcoholics Anonymous, and I wish some of you doctors would come to our meetings. You are always welcome. I have never been so happy. You doctors can help us an awful lot. I have heard some woman say: "He goes to Dr. So-and-So. He hasn't done anything for him." I don't know what they expect you to do for them, make them to tell you the truth. You can build them up physically, but then you are practically through. Then it is up to the individual to go the road that he chooses, but a man has to be built up physically to get along. You wouldn't play in a football game if you were sick and you wouldn't put a horse in a race if he were lame, therefore, you doctors do a wonderful job in getting the patient physically well.

You might compare Alcoholic Anonymous to the work of the three-cornered stool wherein one leg is the medical profession, another leg is the higher power, and the other leg is the Alcoholics Anonymous group, who do help one another.

It reminds me of the story of a man who had a garden in the country, a flower garden. So he said to his preacher: "I would like you to come out and see the flowers I have grown." And the preacher said he would be glad to go and out he went. He showed the preacher. He had worked like a mastiff for two or three months, and said: "How do you like the flowers I have grown?" The minister looked at him and said: "You didn't grow those. God grew them." The man looked at him and said: "Maybe you are right, but you should have seen that garden when God had it alone."

So that is the way we are. We cannot do it alone. We have to have the help of the medical profession. We have to have the help of Almighty God.

DR. DAVIS: Thank you very much.

There are 50,000 more who have found sobriety through Alcoholics Anonymous, if not 70,000, they come from mental institutions, the house of correction, the Salvation Army. It makes us stop and think. Is it so hopeless? The problem of alcoholism has challenged the best minds of the world, and in this age of atomic confusion we would be conceited indeed to think that we have the answer to this problem.

I trust that when our work is closed and over, the generations of doctors to come can say, "Well, they had an intelligent attack." I don't know that we have the answer, but our prayer is that our attack is intelligent.

For ordinary purposes drinking can be divided into two types of drinkers. There are many more, but for our purposes two types will suffice—the social drinker, and the problem drinker or the alcoholic. I think I might just paint a pattern of the alcoholic as he drinks.

If we are ordained by some power to be social drinkers, it is not an important part of our life. We can drink or we can leave it alone. We can take a cocktail or two before dinner and not drink another for the next two or three days, or three weeks, but the alcoholic is entirely different. He is never any further away from trouble than that first drink. It is described in this way that the alcoholic has an obsession to drink, that he manages his whole problem of living with alcohol as being the most important, and if he succumbs to that obsession then the drink-

ing becomes compulsive and after the first drink he has no control whatsoever over his drinking.

How do we diagnose an alcoholic when there are no laboratory tests to say this man is an alcoholic and that man is a social drinker? We have to go entirely on the empirical formula of the man's behavior pattern, and one of the most cardinal factors in isolating the alcoholic is blanks. The individual who takes a cocktail at five o'clock, but does not remember where he has been from six to twelve, the individual who starts out on a social evening and sneaks out to the garage the next morning to see if all the fenders are still on the car — he knows he drove the car home and that is all — that is a very cardinal sign of alcoholism, the disease as they speak of it today. He is the individual who, when he takes a cocktail prior to dinner, never gets to the dinner but continues drinking. He is the individual who takes a drink the next day. Usually, when the alcoholic starts drinking he continues to drink until nature of its own accord starts a sobering up process in sickness and yet you would think with such horrible physical agony that in itself would be a lesson that would make the man awaken to his problem, but with the first de- the first drink and the vicious start is repeated. gree of health and feeling of wellbeing he takes

Alcoholism is a disease that destroys a man mentally, physically, and spiritually. We know full well the mental poverty of the alcoholic. We know that the alcoholic under influence of beverage is insane. How else can we explain—and this is a true statement, that the alcoholic does love his wife and he does love his children—then how can you explain a man loving his children and then coming in and beating the daylights out of them? Yet that is what they do. It must be a phase of mental illness that is severe.

Then you see the man who is punctual in business, the man who built up a business, the man who is neat of appearance, his clothes are fashion-plate and a few years later you see him unshaven, his clothes are dirty. There is a marked poverty in these individuals. And the beauty of it is the men who have the wherewithal to get to high executive positions and then fall or become addicted to alcoholism, but arresting this disease, can again climb the ladder to success.

We commonly think of alcoholics as the bums around Vine Street, but that is not necessarily true. Alcoholism as a disease strikes among our worthwhile people. Who are alcoholics? Judges, psychiatrists, doctors, educators, and a very strange thing is that the more education a man has the higher the incidence of alcoholism. We must assume from these facts that the alcoholic is a worthwhile person. I mentioned the doctor and the psychiatrist, but even the clergymen are stricken with this disease. It seems impossible, but if our empirical information is correct, if a person is an alcoholic, then sacramental wine is sufficient to start a binge, and I have in my practice several Protestant clergymen who, when they give communion, have grape juice in their communion cups and the communicants receive the sacramental wine, because they have learned of their extreme sensitivity to alcoholic beverage, and they know that they cannot drink.

The time is very short, and one who is interested in the problem can talk, but there are a few thing I would call to your attention in the matter of treatment. We treat them for five days in the clinic, but here are the things that I think doctors must be aware of. So many doctors tell their patient—and this is not a criticism—that what you need to do is just drink beer, and those of us who work with the alcoholic know he hasn't one chance in a thousand of drinking just beer. Or the doctor in his kindness will say: "Well, now, you just take a little port before dinner." But the alcoholic can't control his drinking. The mere fact that a man is alcoholic, means he is an uncontrolled drinker. This makes it dynamite to tell the alcoholic to just drink beer, because you give him medical authority to take that first drink, and we have to pound in his ear again, again and again that he can't take that first drink, but the medical authority says just drink beer and he will drink beer. If the medical authority says to take port wine he will take it.

What are some of the peculiar things that we have learned about this condition and they are empirical? We have men who haven't had a drink for 27 years. They have a car-

diac attack and their family doctor has given them liquor. There is nothing wrong with that, but we do know that people are sensitive to drugs and all of us learn that if a person says: "I can't take morphine," we don't rush to give morphine to them. And here again it is very, very true. These people can't take alcohol, and in our group at the clinic we instruct the men to tell their doctors. It is not the doctor's fault. We tell them to tell the doctor they are alcoholic and they can't take wine, beer, or whiskey. We go further than that. We instruct these men to tell their doctors to give them their medicine in pills or capsules or an aqueous solution because in case record after case record it has been shown that a man has taken a cough mixture and the first thing he is into the cycle of a binge. We have had men dry for one and two years who, because of being a little jittery, go into the corner drugstore and get aromatic spirits of ammonia, and three or four hours after that, without any intention on their part to drink, they find themselves in a barroom, and they don't know why. We ask them to avoid wine, whiskey and beer, cough medicines with alcohol in them and aromatic spirits of ammonia, and they have more to avoid than just alcohol.

The alcoholic cannot take sedatives, and we stress the point that before a man leaves the clinic he must be 72 hours without any sedation whatsoever. Sedation and alcohol are first cousins, or brothers. It gives them the same and similar physiological response, and the "goof-ball" addicts are running wild. Not only does alcoholism come in this, but it is an extreme challenge to American medicine. I have a woman in the hospital now going into her 72nd hour after 75 grains of secanol. It is a bad habit the American people have adopted. We cry about sleep and the one thing that none of us can do is stay awake. Our sleeping rhythm may be disturbed, but there is no such thing as being unable to sleep, and the American dependence on sedatives is disgusting to say the least.

But speaking primarily of the alcoholic, when you get alcohol addicts coupled with "goof-ball" addicts you really have a problem on your hands. We stress to these men to sweat it out. All right, if you don't sleep tonight you will sleep tomorrow night, but please don't take sleeping potions, because if you give or prescribe sleeping potions or sedatives it is an open invitation to another binge. Those are the things that we would like physicians to be aware of, the extreme sensitivity of these individuals.

Another example of sensitivity, a man who has been dry for two years. He had a very gracious and lovable landlady, who said, "I have the very thing for you." She went downstairs and heated some wine for him. He had been in bed a day or two. Fifteen minutes after he had the wine he was dressed, out of the house and in the saloon. That is what makes us feel there must be an extreme sensitivity to this particular beverage, and that is why we harp, harp and harp again, you cannot take the first drink.

Now, I know the alcoholic is an atrocious and arrogant, pugnacious and irritating, difficult patient, but it has surprised me in the clinic, with 1500 patients, all alcoholics, all with a serious alcoholic history, that only about 30 of them have been restrained. That amazed me, because my usual program was to send them into mental institutions and they would say: "What am I doing here?" "It is the only place you can be." "It is no good. You are crazy." Day in and day out we had the same thing. And when they left the hospital we didn't know who was madder, the patient at me or me at the patient, and we both had the parting hope that we would never see each other again.

It is amazing to see these men cooperating and not be in restraint, and on the morning after they had been admitted being able to talk to them using the therapy known as group technique. It just baffles me, knowing the stormy days we have had with alcoholics, how they can be so cooperative, how they can be so sincere.

There is one very important thing that I think I must call your attention to. I don't think you can get an alcoholic well unless you can get his family well. Many psychiatrists say that the alcoholic is a neurotic individual. I don't know. He may be. We don't have the answers. But there is one thng I am positive of. His wife and children suffer from a severe neurosis. And why? How can you live through five and six years of intense

agony and intense fear? How can a woman be content and at peace with herself when three or four other men are chasing her husband around because he has a .45 and they don't know whether he is going to commit suicide or kill some one else? How can there be any contentment in that family when the bank account is shaking, when there may be an automobile accident, or when the husband isn't showing up for work? They always live in the dreaded fear of catastrophe; what is going to happen next?

You must get the family of the alcoholic receptive to the idea that these men can be helped—remember, when the alcoholic comes to you, the family is already in that dark chamber of despair, they have given up hope, and it is pretty hard for them to realize that these men can arrest their disease, and you get the attention of the family to the problem of sickness, that in their hearts these men want to get dry, they know they cannot drink, but they don't know how under the sun to tackle their problem, if the family can appreciate that dad is sick and not a drunken bum, the child doesn't have to walk forth with stigma.

I think alcoholism is a tremendous challenge to the professions because as you see these hundreds of men and their families smiling and happy and again living their lives anew in a day when we need the intelligence that these men represent, I think it is a worthy challenge to which medicine can lend its support.

DISCUSSION

DR. M. T. TARUMIANZ (Farnhurst): There is very little I can add to Dr. Davis' statement. I certainly am in full accord with his philosophy and medical approach in regard to alcoholism. Whether alcoholism is a disease or a condition, to us that is questionable. We have been discussing alcoholism for the last 37 years since I have been practicing medicine. I have been widely interested in the problem of alcoholics for the last 30 years in this state. I suppose I have treated as many as any average psychiatrist has.

The problem of alcoholism is not a unilateral problem. It certainly involves medicine, physiology, economics, sociology, philosophy, including religion. One can't just classify all who drink excessively into the group of alcoholics without making a distinction as to the cause.

I think, fundamentally, we should as physicians be interested in the cause of the individual alcoholic. Unless we become aware of the problem of the individual who has become alcoholic we could not simply classify all of them as allergic to the drug itself, to the chemical itself. At least in my practice, I have never found many having the same identical symptoms of their conditions. There is always something different in each individual. I am of the opinion, and I would like to emphasize this, that unless we study each individual separately we are hardly in a position to determine the cause. Neither can we depend entirely on the splendid work of the AA. The AA is an adjunct to medicine in regard to alcoholics.

I was one of the first psychiatrists to approve in the American Psychiatric Association and accept the AA as an adjunct to the psychiatric approach. However, I don't believe, and I am sincere about this—I am not criticizing, but I am absolutely sincere—that we simply cannot sober up a person and send him to AA and say, "Well, his problem is solved." I doubt very much that can be done. He is an individual. He has an individual problem. The problem might be economic, sociological, philosophical, or medical. If it is medical, I am sure that you as medical men can adjust that problem. However, from my experience, only a few have medical problems. It is mostly sociological, economic, or philosophical.

Now, those few cases that have some medical problem, such as endocrine disturbance or a physiological disturbance of some description, I think can be solved very easily, but I doubt very much that many general practitioners could assume the responsibility of solving the problems which we call psychiatric problems, or the psychological problems of the individual.

I am sure that Dr. Davis will agree with me that the psychological background of the individual must be studied and studied individually very carefully.

Now, while I have the opportunity, I am sure Dr. Davis would like to hear what I have to say. We have been thinking about this for

many, many years. What could we do in Delaware to become a laboratory for the United States, since Delaware is a small state and we could assume the responsibility of the caring of the alcoholics in the whole state with the approval of the authorities? We intend to open a haven for alcoholics, to go there on a voluntary basis. I am not speaking of neurotics. Naturally, if you go into the matter of alcoholics possibly all of them are, shall we say, psychiatric cases, and they should be admitted to psychiatric hospitals, but from a legal viewpoint you cannot, and it is not fair to the individual to do so. We are very fortunate that we have an observation clinic and the so-called voluntary admission law under which people could come. However, we do not have a budget to take care of alcoholics in Delaware State Hospital. With this new project we will have bed capacity for 100 alcoholics to be treated as long as their condition will require, whether five days or ten days. I don't see how you can limit every one to five days. There might be some who will require psychological study, or psychiatric treatment, on an intramural basis. Some will require longer periods of treatment on an extramural basis. Whatever we decide in regard to that individual, he will have an opportunity to go there on his free volition and be treated as a human being just the same as he would go for any other problem to any general hospital. If he is well situated financially he can pay for the expenses involved in his care. If not, the state will assume the responsibility.

Now a hundred beds for the state of Delaware is a tremendous asset in my humble judgment, and this will be the only state which will give complete care and treatment to all its citizens in the statewide project. You might not recognize at the moment but each of you have many cases that eventually will become alcoholics. Maybe we will be fortunate enough to get Dr. Davis to be our physician who will assume the responsibility, if we can pay him a large enough fee, to come and be on our staff. We intend to have research laboratories, just the same as they have in medical centers. We intend to pay and make it interesting enough for well qualified research men to come there and work in regard to alcoholics.

I have only one question to ask Dr. Davis, otherwise I am in full accord with him, and I am just about as eager to see philosophy injected into medicine, and the sooner we have that we will feel much better, because at the moment we are going too far in commercialism in medicine. I would like to ask Dr. Davis whether in his experience he has found that the majority of the alcoholics who have spent five days and become so-called "cured" did not require and have need for either group or individual psychiatry for a long time to come? That is the only question I have.

I would like to say at this moment that I personally appreciate Mr. Sumner Mullin's frank statement about his condition. I think he described to you very well the situation. However, he didn't tell you why he had to go at 5:20 and have his half pint or pint and then have three shots to go home. Dr. Davis emphasized the fact which is very, very important. It is the dread of going home that nine out of ten alcoholics, whether they are women or men, have that forces them to start with that first drink. First they say: "Well, I will have the courage to face her," or him whoever it might be. Courage? Alcoholics lack courage, the majority of them. That is one of the first symptoms in the psychiatric study of alcoholics. They have false courage, but not a true courage. They have not been able to be honest and frank with themselves, and until they become honest and frank with themselves, just as Sumner Mullin has become, I don't think there is much you can do except sober them up.

DR. DAVIS: Thank you very much, Dr. Tarumianz. I will answer your question in a little roundabout way. I don't think any common denominator in alcoholism can be found. Dr. Ludlum, Dr. Keyes, Dr. Titmeyer are leading our psychology survey and endeavoring to get a competent psychologist so that we will not neglect psychologic study. Dr. Rathmell is leading our biochemical research and we are finding some amazing things as they are screened through. What bio-attack can we have? We are of the humble opinion there is no laboratory means to attack this problem at present.

I did not intend that five days was the treatment. In five days they are sober. I never talk to a man under the influence of

liquor. It is a waste of time. I will not treat a man in the home. It is a waste of time. You will fail and fail again. The only place to treat an alcoholic is in the hospital. Get him dry and then talk to him. We tell them it will take not less than 18 months. We have a follow-up clinic. They are invited to come up and have a cup of coffee with the boys. That must go over a period of 18 months. We invite the men to return to the religion of their childhood if they are so inclined. We call their attention to Alcoholics Anonymous. Some of them are directly referred to psychiatrists, and we attempt to go over the man's problem and direct him into the groove that might help him most.

He has available the Alcoholics Anonymous. He has the open forum which is held weekly in Philadelphia which is primarily for the families, trying to show the family the problem, and we try to get the alcoholics to attend who are opposed to Alcoholics Anonymous because they don't want to belong with a bunch of drunkards, and a lot of families will not go to Alcoholics Anonymous because they will not associate with drunkards, no matter how many drunks are in their family. It is a five-day treatment with a long follow through. Some men grasp enough out of Alcoholics Anonymous in a year or two to stabilize their program of sobriety. There are others who constantly through the years continue their contact with Alcoholics Anonymous. But they have to remember constantly that they cannot drink and they have to go to the fountainhead of information such as Alcoholics Anonymous or the doctors who understand alcoholism to put up any kind of defense.

DR. TARUMIANZ: May I ask Dr. Davis whether he has any experience with neurosurgery in cases of chronic alcoholism? We haven't had many cases, only two, where lobotomy was performed successfully. Possibly some of you have read Dr. Walter Freeman's statistics on chronic alcoholics who had lobotomies, with apparently a high percentage of cure. I would like to know whether you have any experience with this.

DR. DAVIS: I haven't had any experience personally and I don't have the courage to ask for lobotomy.

I reviewed Dr. Freeman's work not so long ago. At that time he had three and has probably added to that list now, but he wasn't very happy about it at that time.

DR. TARUMIANZ: In the last report?

DR. DAVIS: No, it was the former report. I am not aware, since the war, whether he has done any more. I think, as far as I am concerned, I would be much against it until I had a little more information.

DR. MAYERBERG: I think too little stress has been laid upon the benefits that may be derived by the alcoholics from contact with Alcoholics Anonymous. I know both Dr. Davis and Dr. Gehrmann mentioned it. I don't know of any specific treatment in the average alcoholic disease that is the answer, but I do know there are statistics, as given by Dr. Davis, showing 70,000 people in the United States have arrested cases of alcoholism, that while it may not be the answer that it is well on the way to pointing the right treatment.

I believe this organization, Alcoholics Anonymous, has already become a power for good in the country. I believe that some day it will reach out not just to the alcoholics but they will begin to practice preventive medicine. We all believe in preventive medicine. They will reach out and get boys and girls before they even start to drink. Alcoholics Anonymous is a valuable adjunct to the practice of medicine. The doctor, the psychiatrist, and people interested in medicine should do everything in the world to aid this organization, encourage them, attend their meetings, and send people to them because they have been through the mill. They have been drunks. They have been in the gutter. They have been rejuvenated and rehabilitated. They know how to talk to the unfortunate better than we do, better than psychiatrists could possibly talk to them, because most psychiatrists haven't been down as low as they have been. They can't talk the same language, and I say to you, it is your duty as physicians to encourage the contact between physicians and the Alcoholics Anonymous groups. Send your patients to them after you have straightened them out and they will keep them straight.

DR. TARUMIANZ: Mr. President, just one explanation: I think Dr. Mayerberg misconstrued or misunderstood my opinion of the

Alcoholics Anonymous. Certainly I am 100 per cent for Alcoholics Anonymous. I am working for them constantly. My point was that you cannot transfer your duties to Alcoholics Anonymous, that a person still remains a medical problem or a psychiatric problem. They—the AAs—are an adjunct to the medical profession.

NEWER CONCEPTS IN THE TREATMENT OF PEPTIC ULCER*

G. S. SERINO, M. D.**
Wilmington, Del.

Some authorities claim that about 1 in 10 of the adult population at sometime suffers from a duodenal ulcer. Duodenal ulcer may be found in patients of any age, but it is most frequent in the third and fourth decades. Ladd and Gross[1] refer to the presence of ulcers in the stillborn and premature infants.

The pathogenesis of peptic ulcer has been studied both clinically and experimentally by many able investigators. Alverez[2] believes that the hereditary factor is very important. He describes as the "ulcer type" the keen, alert, sensitive man who is constantly driving himself. This description is substantiated by ample clinical proof. Any nutritive injury to the duodenal mucosa from any cause makes possible a digestion of tissue and may give rise to ulcer formation. Focal and alimentary infections undoubtedly play an important part. Duodenal ulceration has been produced by the intravenous injections of certain strains of streptococci. We are all aware of the flareup in symptoms caused by the common cold.

Another aspect of primary importance is the vascular. Various investigators have called attention to the fact that anatomically the duodenal cap is poorly supplied with blood, with an arrangement that probably predisposes to thrombosis. The influence of vasomotor spasm in the production of relapses is well known. Boles[3] compares the increased incidence of duodenal ulcer during the past 25 years to an increasing incidence of vascular disease. That venous thrombosis occurs more frequently in the spring and fall months of the year and that it is less prevalent in winterless areas, is of interest because of the similarity in behavior to the ulcer problem.

Gastrointestinal manifestations of allergic disease were recognized by Osler[4] in 1904. Crispin[5] in 1915, observed by x-ray, in a patient with hematemesis, a transient lesion at the pylorus which was found at operation to be due to angioneuratic edema. Friesen et al[6] in a recent paper presented evidence that experimental gastrointestinal edema resulting from local antigenantibody reaction favors the development of the histamine-provoked ulcer in dogs and abets the ulcer diathesis.

The influence of the nervous system in the etiology of ulcer is no doubt very important. The predisposing factor establishing the so-called "duodenal stomach" is the relative increase in vagus excitation established by diminished sympathetic control or by increased vagus stimulation. It has been shown that nicotine paralyzes the synapses of the sympathetic nervous system, and the influence of excessive use of tobacco on patients with ulcer in the production and prevention of healing has been commented on by many observers. Cushing[7] calls attention to the part that the interbrain plays in connection with the parasympathetic system and emphasizes the relation between peptic ulcer and stimulation of the interbrain.

The experimental work of many observers, including Marton[8], has definitely shown that whatever may be the cause or causes of local necrosies, the digestive action of the gastric juice is the important factor in the conversion of an area of necrosis into an actual ulcer. Ulceration of the duodenum and stomach has been produced experimentally in animals by Walpole[9] and others. Histamine in beeswax was implanted in the muscles, and the effects were attributed to the prolonged, sustained secretion of an acid gastric juice. While the initial production of duodenal ulcer may be understood, the factor or factors in the persistence of the ulcer or its tendency to recurrence have not been adequately explained by either clinical or laboratory investigators.

The consensus of opinion is that peptic ulcer is a medical problem and that operations should be reserved for the familiar complications of perforation, hemorrhage, obstruction, and so-called intractability. The medi-

*Read before the St. Francis Hospital Staff, March 23, 1948.
**Chief in Surgery, St. Francis Hospital.

cal control of ulcer and its attendant acid secretion is attempted by rest, diet, no tobacco, no alcohol or coffee, and an attempt to lead a calm and imperturbed life. The physician assumes a definite responsibility in caring for these patients, as the complications carry a decided threat. There is a medical mortality which must be considered in the final analysis. An interesting addition to the medical treatment of ulcer is the use of extracts and hormones. Ivy and his group are using exterogastrone which is obtained from the small intestine of hogs. It inhibits gastric secretion and motility. Sandweiss and his co-workers isolated an anti-ulcer principle in human urine called urogastrone. This acted as a depressant of gastric secretion and appeared to increase cellular resistance and thereby provided immunization against ulcer. If this work is sustained, a definite contribution to the management of peptic ulcer may be expected.

The complications of peptic ulcer are many and varied, are the principle cause of mortality, and constitute the chief indications for surgery. The prevailing opinion is that the surgical treatment should be limited to the complications.

Pyloric obstruction may result either from edema, spasm, or cicatricial stenosis. These may be distinguished on the basis of the clinical course or by the response to medical treatment. In the acute type continued medical treatment is warranted so long as the treatment relieves the obstruction. In the chronic stenosing obstruction surgical treatment is necessary. In obstruction of either type the stomach is decompressed by continuous suction. Attention is directed toward correction of deficiencies induced by chloride and protein depletion, anemia, dehydration, and avitaminosis. Antispasmodics usually prove effectual in stenosis resulting from spasm and edema but not in cicatricial stenosis.

The simple relief of the mechanical obstruction by means of pyloroplasty of gastrojejunostomy is not sufficient. The immediate results of the palliatine measures are excellent; too frequently however, recurrences of ulcer activity or the appearance of anastomotic ulcer interferred with the permanency of the result. For this reason the more recent practice has been to employ partial gastrectomy, removing the distal two-thirds to four-fifths of the stomach. Section of the vagus nerves, as advocated by Drafstedt[10], is the most recent development in the surgical treatment of peptic ulcer. Dragstedt has advised combining vagatomy with gastrojejunostomy as a safer and less radical procedure than subtotal gastrectomy in the treatment of pyloric obstruction. This procedure is now in the phase of critical analysis.

Hemorrhage is responsible for about 18 per cent of deaths from peptic ulcer. Clinically there are two groups of cases which must be distinguished. First there is a large group in which moderately severe or intermittent bleeding occurs and in which there is either clinical response to conservative measures or a sufficient interval between recurrences so that elective surgical treatment may be undertaken. Second, there is a smaller group in which massive uncontrollable hemorrhage continues to a fatal termination. In this group operation during active bleeding may prove to be a life-saving measure. During the period of shock and vomiting feedings are neither desirable nor possible. Following a hemorrhage a period of starvation is no longer an accepted form of treatment. The articles by Backus[11], Meulengracht[12], Andresen [13] and Lenhartz on this phase of the subject are now accepted methods of treatment of ulcer not complicated by bleeding. Allen [14] has shown that age is the most important factor in mortality from acute massive hemorrhage. This is dependent on the arteriosclerosis in the wall of the bleeding vessel whereby its power of contractibility fails. Allen and Benedict[15] have shown that the most important factor in prognosis of hemorrhage was age. In patients younger than 45 years the mortality on conservative treatment was less than 5 per cent. In patients older than 45 years the mortality was 30 per cent. Severe hemorrhage must be regarded as potentially fatal. Continued bleeding, despite transfusion, is the primary indication for surgery, and the earlier the surgery the lower the mortality rate.

Acute perforation of peptic ulcer results from a penetration of the ulcer through all coats of the organ involved, with the escape of its contents in the general peritoneal cavity.

DeBakey[16] has shown that there is an apparent increase in the incidence of this complication. The diagnosis of acute perforation is an absolute indication for surgical operation. Certain atypical forms of acute perforation, including the subacute type as described by Lund [17], and the intermittent leakage type as described by Singer [18], do well without surgical operation. This has led to the concept of non-operative treatment of perforated ulcer as advanced by Wagensteen[19] and Taylor[20]. However, the experience of Jackson and Metheny[21], Barbour and Madden[22], and Olson and Norgee[23], indicates extremely high mortality following non-operative treatment.

With reference to closure of the perforation many special methods have been devised. This has been described by Gatch and Owens[24], Graham and Tovee[25], and others. In experimental work it was found that living omental grafts were highly resistant to digestion and infection and that they allowed gastric defects ample time to heal. We have been using the graft procedure since 1945 in all operations for acute perforations and believe this has been a factor in attaining a creditably low mortality rate.

We no longer use drainage of the abdominal cavity in cases of perforated ulcers. This plan was advocated by Thompson[26] to further reduce the mortality rate. Following operation, continuous gastric suction should be employed until danger of leakage and the possibility of obstruction has been eliminated. Fluids, amino-acids, vitamins, penicillin, or sulfa drugs or streptomycin, are used as indicated. Special attention is directed to the circulatory and respiratory systems.

In a study of wound healing following perforation Meade[27] found that peritoneal drainage is not needed in any case when the perforation can be satisfactorily closed and there is no walled-off pus.

Vagotomy is the most recent surgical approach to the treatment of peptic ulcer. The relationship of the vagus nerves to normal and pathologic gastric physiology has been studied for many years. The cephalic phase of gastric secretion mediated by the vagi was first demonstrated by Pavlov[28] in 1908. This was later confirmed by Ivy[29] and Farrell[30].

Vagotomy as a treatment for peptic ulcer was advocated by Stierlin[31] in 1920. Dragstedt's[32] first report of total vagotomy, and other papers which followed, have caused renewed interest in the problem. In 1929 Hartzell[33] reported that after transthoracic vagotomies on dogs complete section of the nerves induced a decrease in acid secretion, and that transabdominal vagus section showed no constant decrease in the height of acid. If the vagotomy was incomplete, no decrease in acid secretion resulted. In 1938, Winkelstein and Berg[34] reported that vagotomy alone or in combination with other surgical procedures seemed highly desirable in the therapy of peptic ulcers. In 1944, Weinstein et al[35], while studying the problem of vagotomy, stated that "in none of the cases was cleancut evidence of beneficial therapeutic effect obtained." Miller and Davis[36] have expressed the opinion that transthoracic approach to the vagi is the one of choice. Walters and colleagues[38] stated that in 90 per cent of cases a transabdominal subdiaphragmatic approach will allow as nearly a complete division of the gastric nerves as the transthoracic route. Each of these approaches has its advantages and disadvantages. At the present time a majority of surgeons prefer the transabdominal approach. The subdiaphragmatic approach for vagotomy is to be desired since it provides opportunity to inspect the operative field and examine any complicating features. Vagotomy may then be supplemented by whatever additional surgery is required. The insulin test as advocated by Hollander[37] is used following vagotomy to determine whether or not a completed vagotomy has been accomplished. That it is possible to overlook fibers of the vagus nerve seems to be agreed upon by most observers.

The operation of vagotomy has produced both favorable and unfavorable results. Our own results following vagotomy are too recent for proper evaluation at this time. Walters[38] reports 2 deaths from unsuspected perforation following vagotomy. Other unfavorable results of vagotomy are diminished or absent motility of the stomach, dilatation and retention, epigastric fullness, nausea, vomiting, and diarrhea. Urechline has been used to relieve the retention and dilatation. It is much too

soon to appraise the eventual consequences of vagotomy. The direct effects on the stomach, liver, pancreas, and intestines remain to be evaluated.

Gastric ulcer presents a serious problem in its treatment because of possible malignant degenerative changes arising in a benign ulcer and especially because of the considerable percentage of diagnostic errors made in distinguishing between benign and malignant ulceration. Here the treatment should be primarily surgical.

SUMMARY

1. The incidence and pathogenesis of peptic ulcer are discussed.
2. Newer concepts in the therapy of peptic ulcer are presented.
3. Peptic ulcer is primarily a medical problem. The surgical indications are presented.
4. The operation of vagotomy is presented with both its favorable and unfavorable results.

REFERENCES

1. Ladd, Williams E. and Gross, Robert E.: Abdominal Surgery of Infancy and Childhood, Phila., W. B. Saunders Co., 1941, p. 19.
2. Alvarez, Walter C.: Light from the Laboratory on Causes of Peptic Ulcer, Am. J. Surg. 18: 209, 1932.
3. Boles, Russell S.: Modern Medical and Surgical Treatment of Peptic Ulcer, J. A. M. A. 136: 529, 1948.
4. Osler, William: On the Surgical Importance of the Visceral Crises in the Erythema Group of Skin Diseases, Am. J. M. Sci. 127: 751, 1904.
5. Crispin, E. L.: Visceral Crises in Angioneurotic Edema, Collected Papers of Mayo Clinic 7: 823, 1915.
6. Friesen et al.: Allergic Gastric and Duodenal Edema, Surg. 23: 167, 1948.
7. Cushing, Harry: Peptic Ulcers and the Interbrain, S. G. & O. 55: 1, 1932.
8. Morton, C. B.: Experimental Peptic Ulcer, Ann. Surg. 85: 207, 1927.
9. Walpole, S. H., Varco, R. L., Code, C. F., and Wangensteen, O. H.: Production of Gastric and Duodenal Ulcers in the Cat by Intramuscular Implantation of Histamine, Proc. Soc. Exper. Biol. and Med. 44: 619, 1940.
10. Dragstedt, J. R.: Section of the Vagus Nerves to the Stomach in the Treatment of Gastroduodenal Ulcer. Minn. Med. 29: 597-618, 1946.
11. Bockus, H. L.: Gastroenterology, Phila., W. B. Saunders Co., 1943, p. 607.
12. Meulengracht, E.: Treatment of Hematemesis and Melena with Food, Acta Med. Scand. (Supp.) 59: 375-385, 1934.
13. Andresen, A. F. R.: The Treatment of Gastric Hemorrhage, J. A. M. A. 89: 1397-1402 (Oct. 22) 1927.
14. Allen, A. W.: Acute Massive Hemorrhage from the Upper Gastrointestinal Tract, Surg. 2: 713-731, 1937.
15. Allen, A. W. and Benedict, E. D.: Acute Massive Hemorrhage from Duodenal Ulcer, Ann. Surg. 98: 736-749, 1933.
16. DeBakey, Michael: Acute Perforated Gastroduodenal Ulceration: A Statistical Analysis and Review of the Literature, Surg. 8: 852-884 and 1028-1076, 1940.
17. Lund, F. B.: Subacute Perforation of the Stomach with Report of Three Cases, Boston M. and S. J. 152: 516-518, 1905.
18. Singer, H. A.: Perforated Peptic Ulcer With Intermittent Leakage, J. A. M. A. 102: 112-117, 1934.
19. Wangensteen, Owen A.: Non-Operative Treatment of Localized Perforation of the Duodenum, Minn. Med. 18: 477-480, 1935.
20. Taylor, H.: Perforated Peptic Ulcer Treated Without Operation, Lancet 2: 441-444, 1946.
21. Jackson, L. E. and Metheny, B.: Thirty Cases of Perforated Peptic Ulcer, Northwest Med. 42: 367-368, 1943.
22. Barbour, R. F., and Madden, J. L.: Acute Gastroduodenal Perforation, Am. J. Surg. 59: 484-495, 1943.
23. Olson, H. B., and Norgee, M.: Perforated Gastroduodenal Ulcer, Ann. Surg. 124: 479-491, 1946.
24. Gatch, W. D., and Owen, J. E.: The Technique of Closing Perforated Ulcer of the Duodenum, Ann. Surg. 105: 750-757, 1937.
25. Graham, R. R., and Tovee, E. D.: The Treatment of Perforated Duodenal Ulcer, Surg. 17: 704-712, 1945.
26. Thompson, H. L.: Complications of Peptic Ulcer, J. A. M. A. 136: 752-758, 1948.
27. Meade, R. H.: A Study of the Healing of Abdominal Operative Wounds Following Closure of Perforated Ulcers of the Stomach and Duodenum, Surg. 14: 526-530, 1943.
28. Pavlov, I. P.: The Work of the Digestive Glands, 2nd Eng. ed. London: C. Griffin and Co., 1910.
29. Ivy, A. C.: J. A. M. A. 88: 1072, 1925.
30. Farrell, J. I.: Am. J. Physiol. 85: 685, 1928.
31. Stierlin, E.: Deut. Zschr. Chr., 152: 358, 1920.
32. Dragstedt, L. R.: Arch. Surg., 44: 438, 1942.
33. Hartzell, J. B.: The Effect of Section of Vagus Nerve on Gastric Acidity, Am. J. Physiol. 91: 161-171, 1929.
34. Winkelstein, A., and Berg, A. A.: Vagotomy Plus Partial Gastrectomy for Duodenal Ulcer, Am. J. Digest. Dis. 5: 497-501, 1938.
35. Weinstein, V. A., Colp, R., Hollander, F., and Jemerin, E. E.: Vagotomy in the Therapy of Peptic Ulcer, S. G. & O. 79: 297-305, 1944.
36. Miller, E., and Davis, C.: The Anatomic Study of the Vagus Nerves, J. A. M. A. 133: 461-462, 1947.
37. Hollander, F.: The Insulin Test for the Presence of Intact Nerve Fibres after Vagal Operations for Peptic Ulcer, Gastroenterology 7: 607-614, 1946.
38. Walters, W.: A Study of the Results Both Favorable and Unfavorable of Section of the Vagi Nerves in the Treatment of Peptic Ulcer, Ann. Surg. 126: 679-686 (Nov.) 1947.

TOXIC ADENOMA OF THE THYROID
Co-Existing With Carcinoma of the Uterus
A Case Report

FRANK J. GILDAY, M.D.*
Wilmington, Del.

In scanning the literature nothing was found in reference to nodular goiter associated with fundal carcinoma. The following case report may therefore be of interest.

CASE REPORT

Case 323, from the service of Dr. G. S. Serino**. A. M. a white female, age 52, a stenographer, was admitted to the hospital on 18 February 1945 with vaginal bleeding. Menstruation had ceased in 1941. In June 1944 she first noticed a vaginal discharge which was "light red" in color, nonodorous, and not associated with any pain. The discharge persisted until February 1945 at which time there was an episode of profuse painless bleeding. Since the onset of illness there had been accompanying "nervousness" manifested by irritability, sweating, weakness, tacycardia, and diarrhea.

Physical examination—On admission the temperature was 98.6 °F, respirations 20, pulse 90, and blood pressure 158/100. The patient was not acutely ill. There was increased tactile fremitus, and fine rales at the base of the left

*From the Department of Surgery, St. Francis Hospital.
**Chief in Surgery, St. Francis Hospital.

lung. The remainder of the physical examination was negative, save for a small mass in the right lobe of the thyroid gland, which was firm, non-movable, and non-tender.

Laboratory data—The hemoglobin was 85 percent, the RBC 5,000,000; WBC, 8,000. The urine showed a trace of albumin, and many white and red blood cells. The BMR on 18 February was plus 46 percent. Another on 26 February, after the patient was prepared for surgery, was plus 26 percent. The blood urea nitrogen was 9 milligrams percent. Roentgenogram of the chest was negative for intrathoracic growths, or pathological changes in the lungs.

On 3 March 1945 under avertin, nitrous oxide, and oxygen, a subtotal thyroidectomy was performed. Gross examination of the specimen by Dr. Douglas M. Gay† revealed a nodular thyroid mass, weighing 57 grams. The tissue was disintegrated, but it appeared to consist of nodules of various color and consistency. Microscopic examination showed the nodules consisted of small follicles lined with cuboidal epithelium and an abundance of colloid. The pathological diagnosis was toxic nodular goiter.

The patient had an uneventful recovery, and on 17 March 1945 was again taken to the operating room where a diagnostic D & C was performed. The uterus was slightly enlarged. A sound was passed to a depth of 3½ inches. It appeared that the uterine wall had been penetrated by a growth. The pathological diagnosis by Dr. Gay was adenocarcinoma of the uterus. The patient refused pelvic surgery at this time, and requested her discharge from the hospital.

Readmission on 10 April 1945 showed an RBC of 4,110,000; WBC, 5,400; and hemoglobin 79 percent. The urine showed a trace of albumin. The blood sugar was 90 milligrams percent, and the blood urea nitrogen was 12 milligrams percent.

On 12 April 1945 under avertin and ether anesthesia, operation was performed. The operation, begun with the hope of making it radical proceeded as follows: The round ligament was identified at the internal inguinal ring, clamped, and divided. The ovariopelvic ligament containing the ovarian vessels was clamped and divided. The ureter was identified prior to the placing of clamps. The uterus was drawn to the opposite side by firm traction on the two forceps. The other forceps are separated and the broad ligament is opened up widely. This was carried out by inserting the fingers between the leaves of the broad ligament, and incising the anterior fold of peritoneum outside and parallel to the ovarian vessels. The regional nodes lying along the uterine, external and common iliac vessels were removed. A similar procedure was done on the opposite side. Panhysterectomy was then performed.

The uterus was slightly enlarged, and contained many subserous nodules. These nodules were firm and cauliflower like in appearance, and had perforated the serosa at the fundus. Lower down on the uterus were found several small myomas. The entire specimen consisted of uterus and cervix with both tubes and ovaries attached. This procedure is that advocated by Johnston***. The microscopic examination by Dr. Gay showed the soft tumor was a low grade adenocarcinoma derived from the endometrium. The diagnosis was adenocarcinoma of the uterus, and myomas of the uterus.

The patient was discharged from the hospital on 24 April 1945 in good condition. On 10 January 1948 examination of the patient revealed she was in good health and there was no evidence of any recurrence of the disease.

†Pathologist, St. Francis Hospital.

***Johnston, H. W.: S. G. & O., Seventy-four: 1003, 1942.

WOMAN'S AUXILIARY: AMA
Chicago, June 21-25, 1948

A most cordial invitation is extended to all women, who are Auxiliary members or guests of physicians attending the convention of the American Medical Association, to participate in all social functions and attend the general sessions. Whether Auxiliary members or not, the wives of doctors will be most welcome.

Auxiliary headquarters will be on the mezzanine floor of the Hotel LaSalle. All meetings and functions will be held at the Hotel LaSalle unless otherwise stated in the program, or announced during the meeting. Please register early and obtain your badge and program of the social function.

All tickets should be purchased soon after arrival. These will be sold at the Auxiliary headquarters. All meetings and social affairs

will begin at the time scheduled. Please be prompt. Registration hours are:

Sunday, 2:00 p.m. to 4:00 p.m.; Monday - Wednesday, 9:00 a.m. to 4:00 p.m.

PROGRAM

PRECONVENTION MEETINGS
SUNDAY, JUNE 20, 1948

COMMITTEE MEETINGS

2:00 p.m. to 4:00 p.m.

Registration (mezzanine floor)

8:00 p.m.

Finance Committee—Room B (mezzanine floor)
Mrs. Scott C. Applewhite, chairman

MONDAY, JUNE 21, 1948

9:30 a.m.

Board of Directors—Room B (mezzanine floor)
Presiding, Mrs. Eustace A. Allen, president

10:00 a.m.

Nominating Committee—Room A (mezzanine floor) Mrs. David W. Thomas, chairman

12:30 p.m.

Luncheon of Board of Directors—Room C (mezzanine floor)

4:00 p.m.

Tea in honor of Mrs. Eustace A. Allen, President and Mrs. Luther H. Kice, President-elect, Woman's Auxiliary to the American Medical Association, Century Room..

Tickets $1.25. All doctor's wives cordially invited.

Hostesses: Auxiliaries to the Illinois State Medical Society and to the Chicago Medical Society.

8:00 p.m.

Revisions Committee Meeting—Room B (mezzanine floor) Mrs. Roscoe E. Mosiman, chairman

TUESDAY, JUNE 22, 1948

9:00 a.m.

Formal opening of the Twenty-fifth Annual Meeting of the Woman's Auxiliary to the American Medical Association, Illinois Room (mezzanine floor)

Presiding ..... Mrs. Eustance A. Allen, president

Invocation ..... Reverend Charles Ray Goff, D.D., pastor, Chicago Temple, First Methodist Church

Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association
Mrs. Jesse D. Hamer

Greetings ..... J. Roscoe Miller, M.D., President, Chicago Medical Society

Address of Welcome..... ..... Mrs. John Soukup, Immediate Past President, Woman's Auxiliary to the Illinois State Medical Society.

Response ..... Mrs. Robert Flanders President Woman's Auxiliary to the New Hampshire Medical Society

Presentation of Convention Chairman
Mrs. Rollo K. Packard

Presentation of President-elect
Mrs. Luther H. Kice

Introductions ..... Mrs. Eustace A. Allen

Roll Call ..... Mrs. George Turner
Constitutional Secretary

Minutes of the Twenty-Fifth Annual Meeting
Mrs. George Turner

Convention Rules of Order
Mrs. John S. Bouslog

Credentials and Registration
Mrs. James M. McDonnough

Address of the President
Mrs. Eustace A. Allen

Reports of Officers

President-elect ..... Mrs. Luther H. Kice
First Vice-President .... Mrs. David B. Allman
Second Vice-President, Mrs. Leo J. Schaefer
Third Vice-President ..... Mrs. E. Arthur Underwood
Fourth Vice-President .... Mrs. W. W. Potter
Treasurer ..... Mrs. Arthur A. Herold
(including the report of the Auditor)
Constitutional Secretary, Mrs. George Turner

12:00 p.m.

Luncheon in honor of the Past Presidents of the Woman's Auxiliary to the American Medical Association, Grand Ballroom (19th floor)
Tickets $3.50

Mrs. Rollo K. Packard, past president, presiding

Guest Speaker: Morris Fishbein, M.D., Editor, Journal of the American Medical Association and Hygeia.

AFTERNOON SESSION

2:00 p.m.

Report of the Board of Directors
Mrs. Eustace A. Allen

Reports of Chairmen of Standing Committees:

Editorial ..... Mrs. James P. Simonds
Finance ..... Mrs. Scott C. Applewhite
Hygeia ..... Mrs. Arthur I. Edison
Legislation ..... Mrs. Bruce Schaefer
Organization ..... Mrs. David B. Allman
Post-War Planning .... Mrs. Rollo K. Packard
Program ..... Mrs. Ralph Eusden
Public Relations, Mrs. Harold F. Wahlquist
Revisions ..... Mrs. Roscoe E. Mosiman

Report of the Historian
Mrs. Jesse D. Hamer

Report of the Central Office and Bulletin Circulation
Miss Margaret Wolfe

Report of the Nominating Committee (first reading)
Mrs. David W. Thomas, chairman

Election of the 1949 Nominating Committee

4:00 p.m.

Round Table Discussion:

Hygeia ..... Mrs. Arthur I. Edison
Legislation ..... Mrs. Bruce Schaefer
Program ..... Mrs. Ralph Eusden
Public Relations, Mrs. Harold F. Wahlquist

8:00 p.m.

Opening Meeting of the American Medical Association, Grand Ballroom, Hotel Stevens. Members of the Woman's Auxiliary and guests are welcome.

WEDNESDAY, JUNE 22, 1948

9:00 a.m.

General Session of the Woman's Auxiliary to the American Medical Association, Illinois Room (mezzanine floor)

Presiding ..... Mrs. Eustace A. Allen
Greetings ..... Warren W. Furey, M.D., Chairman Local Committee on Arrangements, A. M. A.
Minutes ..... Mrs. George Turner
Announcements ..... Mrs. Rollo K. Packard
Credentials and Registration ..... Mrs. James M. McDonnough
In Memorian ..... Mrs. Van Buren Philpot
Resolutions ..... Mrs. Henry Garnjobst
Reports of State Presidents

12:30 p.m.

Annual Luncheon in honor of Mrs. Eustace A. Allen, President and Mrs. Luther H. Kice, President-elect, Grand Ballroom, (19th floor)

Tickets $3.50

Mrs. Eustace A. Allen, Presiding

Guests of Honor: Dr. Edward L. Bortz, President; Dr. R. L. Sensenich, President-elect; Dr. J. J. Moore, Treasurer; Dr. George F. Lull, Secretary and General Manager; Dr. Morris Fishbein, Editor of the Journal and Hygeia; and the members of the Advisory Council of the Woman's Auxiliary to the American Medical Association.

2:00 p.m.

Joint meeting of the Advisory Council of the American Medical Association and the Board of Directors of the Woman's Auxiliary

AFTERNOON SESSION

2:30 p.m.

Unfinished Business
New Business
Report of the Nominating Committee
Mrs. David W. Thomas
Election of Officers
Installation of Officers and Presentation of President's Pin
Mrs. Frank N. Haggard
Inaugural Address ..... Mrs. Luther H. Kice
Courtesy Resolution ..... Mrs. Arthur J. McCarey
Minutes ..... Mrs. George Turner
Adjournment

THURSDAY, JUNE 24, 1948

9:30 a.m.

Meeting of the Board of Directors, Room B (mezzanine floor)

Mrs. Luther H. Kice, presiding

6:30 p.m.

Annual Dinner of the Woman's Auxiliary for members, husbands and guests, Grand Ballroom (19th floor)

Tickets $4.00

9:00 p.m.

Reception and Ball in honor of the President of the American Medical Association—Palmer House.

FRIDAY, JUNE 25, 1948

Exhibits at Navy Pier

Infants of Morphine-Addicted Mothers Born With Same Addiction

Infants born to mothers who are morphine addicts show all the symptoms of a morphine addict whose source of supply has suddenly been cut off, and if not properly treated may die of convulsions during the first week of life, according to an article in the November 8 issue of *The Journal of the American Medical Association*. The author is Meyer A. Perlstein, M. D., Chicago.

"The infants are born at full term and are apparently normal," Dr. Perlstein writes, "but their addiction matches that of their mothers. Separation from the maternal circulation shuts off the supply of drug to the newborn, and withdrawal symptoms ensue within three days. . . .

"In the past, some investigators erroneously assumed that morphine was excreted in human milk; hence, breast-feeding by the addicted mother was a method employed in the treatment of congenital morphinism. It is a fact, though, that morphine is not thus excreted, and the emphasis in treatment is now directed toward sedation."

In the case which Dr. Perlstein mentions, dosage with phenobarbital brought about prompt recovery, the drug being continued for eight weeks before being tapered off and stopped.

Urology Award

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, Massachusetts, May 17-20, 1948.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before March 1, 1948.

+ Editorial +

DELAWARE STATE MEDICAL JOURNAL

Owned and published by the Medical Society of Delaware, a scientific society, non-profit corporation. Issued about the twentieth of each month under the supervision of the Committee on Publication.

W. EDWIN BIRD, M. D. ..... Editor
822 North American Building

GERALD A. BEATTY, M. D. ..... Associate Editor
503 Delaware Avenue

M. A. TARUMIANZ, M. D. .....Assoc. & Managing Editor
Farnhurst, Del.

Articles are accepted for publication on condition that they are contributed solely to this JOURNAL. Manuscripts must be typewritten, double spaced, with wide margins, and the original copy submitted. Photographs and drawing for illustrations must be carefully marked and show clearly what is intended.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus, published by the American Medical Association, Chicago.

Changes in manuscript after an article has been set in type will be charged to the author. THE JOURNAL pays only part of the cost of tables and illustrations. Unused manuscripts will not be returned unless return postage is forwarded. Reprints may be obtained at cost, provided request is made of the printers before publication.

The right is reserved to reject material submitted for publication. THE JOURNAL is not responsible for views expressed in any article signed by the author.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the A. M. A. Advertising forms close the 25th of the preceding month.

Subscription price: $4.00 per annum, in advance. Single copies, 50 cents. Foreign countries: $5.00 per annum.

VOL. 20 MAY, 1948 NO. 5

THE REBELLION OF BRITISH DOCTORS

No single issue confronting the American people holds the sinister menace that is inherent in Federal Compulsory Health Insurance. The implications are not understood. The ulterior motives of the prime sponsors are concealed. However, there is nothing new or experimental in either the concept or the mechanism.

In 1911, Lloyd George, Prime Minister of Great Britain, began to sense the waning of popular support. He forced through Parliament a law imposing a panel system of medical care on the people of England, Scotland and Wales. It was applicable to the rank and file of all employed workers. The system was introduced with the threadbare shibboleths of "bettering the lot of the common people." The real purpose was to bolster a declining prestige and to strengthen political control of the masses.

The thirty-year resultant was mechanical medical care, an appalling use of nostrums and quack remedies and incentives leading to the erosion of the integrity and character of the panel physicians. It is a matter of historical record.

A general election in 1945 brought a Socialist Government to power in England. It was pledged to the Nationalization of all industry. A law was enacted providing free health care to all citizens. Private hospitals—except Catholic institutions—are to be seized and their endowments confiscated. All hospitals will be staffed by full-time doctors on the government payroll. Their status will be reduced to that of civil servants in government employment. All physicians in England are faced with the prospect of a similar status beginning July 5, 1948—when the law will become finally and fully effective.

British physicians have had more that thirty years' experience in a limited form of government medicine. They are fully aware of the impossibility of providing adequate or really effective health services under the restrictions and hampering red tape of bureaucratic administration. They rebelled.

In January, 1948, the British Medical Association conducted a poll of all British doctors. 89.5 percent of the physicians expressed disapproval of the British Health Service Act. 86 per cent of Britain's medical practitioners, specialists and consultants voted to refuse to work under the law that would force them to provide free medical care. They fully understood that such service leads to stultifying abuses by both patients and physicians—health care on the basis of political acceptability rather than medical effectiveness.

British physicians are not on strike. Unanimously they pledge themselves to continue providing medical care where needed. They may or may not be recompensed. However, they will retain their effectiveness, their integrity and their self respect.

There is no more glorious incident in the annals of this nation of free men than the action of British doctors refusing to become party to a scheme designed to centralize political power at the expense of the welfare of the people.

In this action, there is a lesson for us. If heeded, it can well save us in terms of hundreds of millions of dollars and possibly hundreds of thousands of lives.

There is before our Congress a Bill—The Murray - Wagner - Pepper - Chavez - Taylor - McGrath Bill (S-1320) which, if enacted, would force on the American people a free medical, dental, nursing, hospitalization service. On the basis of all experience, it would destroy our system of health care that has placed this country in the position of world leadership in the healing arts. It would rob members of the health professions of their independence, self respect and incentives for progress. It is estimated that the ultimate* cost would approach $20,000,000,000 annually. It would entail an administrative bureaucracy that could become the key instrument in the seizure of tyrannical power.

On March 17, 1948 the British Medical Association met and unanimously adopted a resolution of non-participation under the British National Health Service law.—The present situation is one of stalemate.

Of this action by British doctors in an editorial the *Chicago Tribune* March 23, 1948, states:

"If the fight against regimentation and tyranny by the all powerful centralized state is to be won in Britain, it will be because there are still Englishmen who, like the doctors, have dignity and pride in their attainments as individuals, and who refuse to be reduced to ciphers on the state payroll. By holding fast, the doctors can hope to reverse the tide of socialism and save Britain."

This comment should make crystal clear to American physicians and dentists the important place they now occupy. It should inspire them to more determined efforts to preserve the independence of the professions in this country and our American way of life.

Editorial, *N. P. C.*

* Estimate is for total annual Social Security Expenditures.

SOCIALISM AND MEDICINE IN GREAT BRITAIN

On July 5, 1948, the National Health Services Act will go into effect in Great Britain. The Act will be, when it becomes operative, another step in the nationalization program of the Labor Government. Under it any resident of Great Britain will be entitled to medical care, hospital care, drugs, home nursing, appliances, and limited dental service, regardless of income. All this will be paid for—partly by contributions to the social insurance fund, partly by taxation.

There is said to be free choice of physician under the Act, "but physicians may or may not enter the public service. Hospitals are nationalized but administered by local and regional committees. Health centers are to be established, and, in these, general practitioners will have their offices, so that they may practice ultimately in groups which will have every diagnostic and therapeutic facility at their disposal."[1]

Few things are either as good as they look or as bad as they seem. In Great Britain the National Health Services Act is the legislative product of a Labor Government, duly elected and placed in power by the free voters of the country. It was known to all that such a Government proposed, if elected, to carry out a program of nationalization, and that medical services would be included in such a program. There is in Great Britain, therefore, a certain validity in the establishment of the Act which flows from the obvious desire of the people to install and maintain a socialist regime for better or worse. Under the circumstances the scheme may work since the people want it, seem to be willing to pay for it and to put up with the consequences.

Preceded by war, accompanied by grinding national debt, and followed by strife between the ministry of health and the medical profession, the implementation of the Act by the establishment of rules and regulations seems to be somewhat retarded—not an altogether auspicious beginning, but one to be observed with scientific detachment.

To doctors here, who have followed the program for Great Britain outlined in 1944 by the

[1] New York Times (Jan. 12) 1948, p. 18.

Conservatives and, subsequently, as to medical reform, amplified and enacted by the Labor Government, it will be of interest to observe the process of changeover and adjustment from private to public practice. The shift from conservatism and free enterprise to socialism and state-controlled management of national resources, among them medicine, is a function of poverty. Call it reform or label it any way you please, it is still as simple as that. Confiscatory taxation is a prelude, usually over a period of time, following the Keynesian philosophy that private thrift and saving are to be discouraged and public spending encouraged. Since public spending involves increasing government control of the projects on which public moneys are to be spent, the power of the purse will eventually exert itself through rules and regulations having the force and effect of law.

In Great Britain the rules and regulations which will govern are now in process of being formulated to take effect in July of this year. In its present form, says the *British Medical Journal* "the Act is the first and irrevocable step towards a whole-time State Medical Service (not a 'Health' Service.)"[2]

Be it noted that the dictatorship of the State represented by the current Labor Government is the result of popular acceptance of such a philosophy and that all will have to adjust to it in the end—or change it.

Editorial, *N. Y. St. J. M.*, April 1, 1948.

How Do They Do It?

The J.A.M.A., May 1, 1948, pg. 87, under Residencies and Fellowships in Urology, lists the Letterman General Hospital, San Francisco, as having had last year, four deaths and six autopsies! How do they do it? We are all familiar with the old quip, in reference to doing things: "There's the right way, and the wrong way, and the way the Army does it." Now will the Army please explain these autopsies?

[2] (Jan. 17) 1948, p. 104.

MISCELLANEOUS

V. A. Regulations

Dear Editor:

This office is greatly pleased to welcome you, a member of the Delaware State Medical Society, as a participating fee basis physician of the Veterans Administration. While you may be familiar with the procedures governing services to our veteran beneficiaries, the following aspects of treatment will bear reiteration of our policy:

1. Out-patient treatment may be rendered by you to a service connected veteran when no VA facilities are feasibly available; where it would create undue hardship to the veteran to attend a VA facility; in an emergency.

2. When a veteran requests, from this office, treatment by you under one of the above conditions, we will prepare and forward to you, in triplicate, VA Form 10-2568, Authorization and Invoice for Medical Services. On the face of this form under "Nature of Services Authorized" will be stated the service connected conditions for which the veteran is to be treated. Under "Period Covered by this Authorization" will be stated the time limit covered by this particular authority. If further treatment is found necessary *within* the prescribed period of the current authorization, this office must be notified and the request made. We will then forward you a supplemental authority for the additional treatments. At the end of the month covered by these authorizations, a moderately detailed report of medical treatment rendered must be submitted to this office on VA Form 10-2690A, Report of Medical Treatments Rendered. If additional treatments are deemed necessary for the following month, this fact should be stated directly below the report of treatments rendered, specifying the approximate number of house and/or office calls required for that month. With this report should be sent the two carbon copies of the VA Form 10-2568, Authorization and Invoice for Medical Services, properly filled in on the reverse side with the specific dates and type of treatment rendered and total costs. Only one of these need be signed by you. You should retain the original copy of the VA Form 10-2568 for your files. Prescriptions may be issued under the following circumstances:

(a) It is adamant that you have a current

authority authorizing the treatment of the veteran.

(b) On the face of the prescription must be inscribed—"I am currently authorized to treat this veteran."

(c) The prescription issued must be for the treatment of the veteran's service connected disabilities only.

(d) Prescriptions issued for narcotics must be made in duplicate.

When you write a prescription under the above conditions, the veteran may then take this prescription to any pharmacist who is a member of the Delaware Pharmaceutical Society, where it will be filled and the pharmacist will be assured that he will be paid by the Veterans Administration. However, if you issue a prescription without having a current authority and/or inserting the phrase "I am currently authorized to treat this veteran," the pharmacist who will have in good faith filled it, will not be paid and the prescriptions will be returned to him, since the VA cannot honor payment for any prescriptions except under the above conditions.

3. From time to time a veteran may present himself directly to you for treatment without prior authorization from this office. He may state that he has a service-connected condition. This may be true, but it is equally untrue in as many other cases. Therefore, in order not to jeopardize your chances for payment, it is suggested that you contact this office immediately by telephone or letter requesting whatever treatment you believe necessary for the veteran. This office will then determine if the veteran is entitled to this treatment and, if so, you will be forwarded the authorizations as described in paragraph 2 above. If the veteran is not entitled, we will notify you immediately by letter or telephone.

4. There will be times when you will be called upon to treat a veteran in an emergency. Obviously from a humane point of view, this treatment should be rendered immediately. However, it is incumbent upon you to notify this office within fifteen days of such treatment in order to insure payment for your services. Upon receiving this notification, this office will determine his eligibility for treatment and if entitled, proper authorization will be forwarded to you. Where a prescription must be written for an emergent case, in place of the phrase "I am currently authorized to treat this veteran" substitute the word "Emergency" on the face of the prescription.

5. In summation, Doctor, your cooperation is solicited in following the above procedures to the letter, to insure good medical service to our entitled veterans and prompt payment of your bills. If any problems or questions arise in your mind as to the procedures followed in rendering out-patient service, I shall be pleased to have you contact me personally.

Very truly yours,

M. H. TOLOCHKO, M.D.

Chief Medical Officer.

Surgical Benefit Claims

Boys incure 15% more surgical operations than girls, with 60% of all children's operations being tonsillectomies and 20% appendectomies or fractures, according to an analysis of 100,000 surgical benefit claims of all ages made by a committee of the Actuarial Society of America and presented at the annual meeting of the Society on May 15, in New York.

This was one of a long list of findings from the study which covered group surgical insurance claims reported by companies doing 70% of this type of insurance and covering a period of eight months of last year.

Group surgical insurance, first written in 1938, has become an important segment of the insurance business, covering 10,000,000 persons, the report stated. This insurance, added to protection on an additional 10,000,000 covered by Blue Cross, individual contracts or other plans, gives a total of over 20,000,000 persons now protected by surgical benefit insurance.

Eight types of operations were found to account for the greater part of all surgical benefit claims; tonsillectomy, appendectomy, benign tumor or cyst, hemorrhoidectomy, fracture, hysterectomy, herniotomy, and dilation or curettage. These accounted for 60% of all claims, 57% of the male cases and 67% of the female cases.

Multiple operations take place in a large number of cases, taking advantage of the urgency of the major cause. In 17% of all cases, more than one operation was performed under the one procedure; in the case of claims for

wives, 31% were multiple, for female employees, 24%, for male employees, 15% and for children 5%. In gynecologic surgery, a maximum of 51% was shown. On the average, multiple operation claims were for amounts almost double those for single operations.

More complicated surgery was incurred at ages over 50 in the case of men. For women, the operations were generally more serious than for men at all ages, but the severity changed little with age, except for a slight peak in late child-bearing or post child-bearing years.

Not all surgery is performed in hospitals, the report shows, though most of it is. Men show a higher out-of-hospital surgery incidence than women. In the case of men, 23% of the operations were performed out of hospitals, for children, 16% and for women 11%. The average amount paid for out-of-hospital claims was less than one-third that for hospital surgery.

Taking appendectomy as an example, it was found that 30% of the doctors charged not over $100; 50% not over $125; 80% not over $150; and 90% not over $165.

The analysis was said by the committee to indicate that charges were usually higher for male employees than for women, reflecting the general practice of suiting fees to the ability to pay.

Analysis of surgical fees in the cases covered showed that charges were highest on the west coast, with California showing the highest cost of any state. In California the charges were 39% greater than the U.S. average in non-obstetrical cases and 61% over average in obstetrical; in the Middle Atlantic states, next highest, the charges were 3% and 5% higher than average, respectively. The South Atlantic states showed the lowest cost, 12% and 9%, respectively, below average.

The average surgical claim for male employees was $48, for female employees $63, for wives $71, for male children $34 and for female children $37.

Supplies Needed

Continued aid in the form of medical and surgical supplies from America is needed to prevent widespread suffering and death among the peoples of war-devastated areas throughout the world. The undersigned earnestly request all members of our profession to help us provide such aid through the Medical and Surgical Relief Committee, Inc.

During the past eight years, with little publicity and modest financial support, this Committee has provided more than a million dollars worth of desperately-needed medical, surgical, and dental supplies and publications to stricken areas overseas. These materials are sent to hospitals, physicians and dispensaries giving *free* medical care to the needy.

Our colleagues in Europe and the East are still faced with an appaling lack of basic medical equipment. Some have not even seen a medical journal or textbook printed since the war began, and are woefully uninformed of many of the latest medical advances.

We are able to do a great deal to alleviate this situation through the Medical and Surgical Relief Committee which receives, sorts, reconditions and ships material—ranging from physicians samples to used instruments—in response to authenticated appeals from overseas.

The items most consistently requested and most vitally needed are:

Adhesive tape
Ampoules—all types
Anesthetics — local, general
Antiseptics
Aspirin
Aspirin combinations
Autoclaves
Baby (Bottles
(Cereals
(Clothes
(Foods
(Nipples
Cod Liver Oil
Cotton—gauze (all forms)
Dietary supplements
Germicides
Hospital Ware
Hot Water Bottles and Syringes
Hpyo needles and Syringes
Liver and Iron Capsules
Microscopes
Penicillin (Crystal, Ointment, Tablets)
Quinine—Tablets, Capsules
Rubber Sheeting and Tubing
Santonin and combinations
Scientific Apparatus
Sedatives
Standard Medications for various conditions
Sterilizers
Streptomycin
Sulfas—Tablets and Liquids
Surgeons gloves
Surgeons needles
Surgical instruments
Thermometers (Fever—F. or C.)
Vitamins—all types and strengths for children and adults.

Please forward any such supplies which you and your hospital can donate to this great need to:

The Medical and Surgical Relief Committee, Inc.
Room 328, 420 Lexington Avenue,
New York 17, N. Y.

We urge you to lend your support to this vital work

ALLEN O. WHIPPLE, M.D., Chairman,
Medical Advisory Council.

University of Pennsylvania

On Saturday, June 12, 1948, the Medical Alumni Society of the University of Pennsylvania will hold clinics from 9:30 a.m. to 12 noon at the University Hospital and a luncheon at 1:00 p.m. at the Penn Sheraton Hotel. Dean Starr will review the year's events and plans for the future of the Medical School. Notices will be mailed.

Adult types of pulmonary tuberculosis have shown an alarming incidence among children of school age in all of the wartorn countries; tuberculosis of bone and joints has increased many times; miliary tuberculosis and tuberculous meningitis in children are now common. In every children's hospital I visited I saw ward after ward of the victims of tuberculosis. In one small country, not atypical of others, I learned that to take care of the known cases of bone tuberculosis alone among children, 7,000 new hospital or sanatorium beds were needed. They had only 500 when I was there. Martha M. Eliot, M. D., Am. Jour. Pub. Health, Jan., 1948.

Indianapolis Medical Society

Resolution of April 27, 1948

"We, the members of the Indianapolis Medical Society, do hereby resolve that the welfare of the medical profession, its scientific advancement and the furtherance of public interest are continuously being harmed by organizations which demand compulsory attendance of physicians at meetings.

"To this end we instruct our duly elected delegates to the Indiana State Medical Association to introduce proper measures at the next meeting of the House of Delegates to the effect that all organizations which require compulsory attendance at their meetings no longer be approved by the American Medical Association; and, we further instruct our delegates to use their utmost influence to obtain passage of such a resolution at the earliest opportunity before the House of Delegates of the American Medical Association.

"The Indianapolis Medical Society furthermore instructs its secretary to send a copy of this resolution to every component Medical Society in the United States."

[Ed. Note—The Hoosiers are right; more power to them.]

Hospital Practice Of Medicine

As was reported in the January, 1948, *News Letter,* a special committee on hospitals and the practice of medicine created by the House of Delegates of the AMA rendered a report to the Board of Trustees at the AMA's Cleveland interim session in January. The report, signed by Doctors Louis Bauer and James R. Miller, both members of the AMA Board of Trustees, and Dr. Roy Fouts, a Fellow of the ACR and Speaker of the House of Delegates, is of special importance to radiologists. As it may have been overlooked in the rush of other events, it is reproduced in full below:

"The practice of medicine by hospitals has been a moot subject for many years. Year after year medical societies, including the American Medical Association, have passed resolutions condemning the system whereby a hospital exploits the services of a physician. This has applied particularly to the four specialties of anesthesiology, pathology, radiology, and physical therapy.

"The passing of these resolutions has not accomplished a completely satisfactory solution of the problem. A great deal of further study and experimentation must be had to work out a satisfactory solution of this vexing problem.

"It would appear that at least we should insist upon the following: (1) recognition that the specialties of pathology, radiology, anesthesiology, and physical therapy are the practice of medicine; (2) all specialists in a hospital should be under the jurisdiction of the medical board; (3) all specialists should be on the staff of the hospital and be represented on the medical board; (4) conditions of employment will vary locally and they must have the approval of the medical board of the hospital whose responsibility it should be to see that these provisions are carried out: (5) the interests of the general public should be paramount and local conditions must be taken into consideration; (6) there must be cooperative understandings with the hospitals and specialists groups, and (7) it is recom-

mended that the House of Delegates request the Board of Trustees to appoint a committee to study the various resolutions passed previously by the House and that this committee be directed to arrange conferences with the hospital associations and the various specialist societies, in order that a solution may be worked out which will be fair to all parties and redound to the benefit of the public.

"It is further recommended that the report of this committee, when prepared, be referred by the Board of Trustees to the Judicial Council for such revision of the Principles of Medical Ethics as may be indicated by the content of that report."

The special report was approved by the Reference Committee on Miscellaneous Business under the chairmanship of Dr. E. P. McNamee, and later by the House of Delegates in general session. The committee mentioned in section seven of the report has been appointed and is headed by Dr. Elmer Hess of Erie, Pennsylvania.

Amer. Coll. Radiol. News Letter, May, 1948.

Living Costs Rise Faster Than Physicians' Fees

The cost of living has risen more rapidly than the fees charged by physicians for medical services, according to Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the American Medical Association.

In his new study entitled "Comparative Increases in the Costs of Medical Care and the Costs of Living," Dr. Dickinson stated that the quantity of medical care received by the American people was at least two-thirds more in 1946 than in 1939.

"When the various indexes and ratios are studied," Dr. Dickinson said, "it can be seen that the quantity of medical care received by the American people has probably increased much faster than the increase in the number of physicians. This apparent 'output' per physician doubtless reflects the increasing use of technical assistants.

"Whether one examines the record of total expenditures of the American people for medical care or the prices of significant items during recent years, he comes to the general conclusion that the American people have been fortunate in that the costs of keeping well have not risen as rapidly as the cost of living."

In his new study, just off the press, Dr. Dickinson made extensive use of the price indexes compiled by the U. S. Bureau of Labor Statistics. A four page bulletin contains figures and charts supporting his conclusions.

The Bureau of Labor Statistics index, covering cost of living in 34 cities, was 59 per cent higher in 1947 than in the base period of 1935-39.

The Bureau's 1947 index for all medical care, including drugs, was only 32 per cent above the 1935-39 period. Excluding drugs, the increase was 35 per cent and for drugs only the increase was 15 per cent.

"This doesn't reflect the quantity of medical care," Dr. Dickinson said, explaining that the 1946 index of personal consumer expenditures for medical care was 211, or 111 per cent above the 1935-39 base period.

"A statistician," he explained "arrives at the index of quantity of medical care by dividing the index of expenditures by the index of prices of medical care." Thus, he established that the index of expenditures for 1946, 211, was more than two-thirds higher than the index of prices of medical care, 122.

He used the index of personal consumer expenditures for all medical care items as provided by the U. S. Department of Commerce.

Dr. Dickinson estimated that the quantity of physicians' services—one of the medical care items — was approximately one-half greater in 1946 than in the base period 1935-39, but the number of physicians was only one-seventh greater.

Dr. Dickinson's newest study is the second made within a year. In 1947, he published a study entitled "Is Medical Care Expensive?" In this 12-page pamphlet, Dr. Dickinson said that medical care items as a whole cost the American people $5,600,000,000 in 1946, but that only 3.9 per cent of the total personal consumer expenditures of the American people were spent for these medical care items. This compared with 4.3 per cent in 1940.

He also found in his first study that in 1946 physicians received only 26 per cent of all the dollars spent for medical care as compared with 31 per cent in the base period, 1935-39,

and 32 per cent in 1929, the first year for which the data were gathered and published by the U. S. Department of Commerce. On the other hand, he found that the amount spent for drugs in 1946 had risen to 24 per cent of all dollars spent for medical care as compared with only 21 per cent in the base period, 1935-39, and 20 per cent in 1929.

OBITUARY

WILLIAM H. SPEER, M.D.

Dr. William H. Speer, 60, who served as mayor of Wilmington from 1933 until 1935, died suddenly on May 3, 1948 in the Delaware Hospital where he had been admitted six days before, suffering from pneumonia.

Although in a serious condition when admitted, Dr. Speer had responded to treatment, later, however, he suffered a heart attack and died.

In defeating the late Frank C. Sparks in 1933, his Republican opponent, Dr. Speer became the city's first Democratic mayor since 1917. Two years later he was beaten for reelection by Gov. Walter W. Bacon when the chief executive successfully ran for his first term as mayor.

Dr. Speer was born in Dover on Feb. 5, 1888, the son of Ottomer W. and Emma L. Speer. He was educated in the public schools of this city and was graduated from the Wilmington High Scool, class of 1905.

He entered the University of Pennsylvania in the fall of 1906, and was graduated from the university's school of medicine with a degree of doctor of medicine in 1910. He played football at Penn for four years.

He began the practice of medicine in this city in July, 1911, and became a member of the staff of the Delaware Hospital in the same year. He coached football at the Wilmington High School for several years.

The day after the United States declared war on Germany in 1917, Dr. Speer enlisted in the Medical Corps and was commissioned a first lieutenant. He was released as major in 1919.

From August 1940 until the summer of 1944, Dr. Speer served as chairman of the Emergency Medical Service Committee of the State Council of Defense, organizing first aid throughout the state.

In May, 1945, Governor Bacon appointed him to membership in the State Highway Commission for a six-year term, to succeed A. Frank Fader of Newark.

Dr. Speer had served as chief of staff of the Delaware and St. Francis Hospitals, and was a member of the courtesy staff of the Memorial and Wilmington General Hospitals. He was a former president and secretary of the Medical Society of Delaware, a member of the American College of Surgeons, American Medical Association, the Philadelphia Medical Club, the New Castle Medical Society, and the Military Order of Foreign Wars.

He was a member of the Concord Country Club, all of the Masonic bodies, the Benevolent and Protective Order of Elks, and the Democratic League.

Surviving are his wife, Mrs. Laura Edwards Speer, his father, O. W. Speer; two sisters, Mrs. John W. Foster of Concord Pike and Mrs. Bella Hake who lives in New Jersey, and a brother, Otto W. Speer of Marshallton.

Funeral services were held on May 6th, in charge of Rev. Charles W. Clash, rector of Immanuel P. E. Church.

BOOK REVIEWS

A MANUAL OF PHARMACOLOGY—And Its Application to Therapeutics and Toxicology: By Torald Sollmann, M.D., Professor Emeritus of Pharmacology and Materia Medica, School of Medicine, Western Reserve University. Seventh edition. pp. 1132. Cloth. Price $11.50. Philadelphia: W. B. Saunders Company, 1948.

"Drug therapy seems to stand in the doorway of a new era," says Sollmann, one of the most analytical and critical authors in the whole realm of pharmacology. Hastened by the war, such impressive discoveries have been made in the potent anti-infection agents and in other agents as to inaugurate a new concept of chemotherapy. These Sollmann evaluates accurately, and prints the material that all students should aim to know in ordinary type, and adds the data that would be consulted only as

special occasion arises in small type, the page being conveniently divided into two columns.

This, the seventh edition, of a great book, maintains fully the excellence of its predecessors.

THE ACUTE BACTERIAL DISEASES—Their Diagnosis and Treatment: By Harry F. Dowling, M.D., F.A.C.P., Clinical Professor of Medicine, George Washington University; Chief, George Washington Medical Division, Gallinger Municipal Hospital. With the Collaboration of Lewis K. Sweet, M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and Harold L. Hirsh, M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. Pp. 465, with 55 figures. Cloth. Price, $6.50. Philadelphia: W. B. Saunders Company, 1948.

It is the purpose of this volume to combine recently acquired knowledge of diagnosis and treatment of acute bacterial diseases with that which is older but still useful. Careful examination of the text fails to reveal any instance in which this purpose is not carried out —thoroughly, practically and satisfactorily. However, the scope of the work is carefully restricted to bacterial diseases in their acute manifestations. Such acute infections as those due to rickettsia, and virsuses are discussed only when they complicate the differential diagnostic problem.

The first chapter takes up this matter of diagnosis and groups the diseases according to a conspicuous symptom, association, or location: fever, eruption, pharyngitis, pulmonary infiltration, the meninges, arthritis. For each of these there are tabulations of the diseases which might be concerned, and suggestions for the diagnosis of each, together with the page in the book where further details will be found. This is an exceedingly valuable chapter, reference to it will unfailingly conduce to a systematic and complete study of all the possibilities and tend to eliminate superficial conclusions.

The second chapter deals with general measures useful in treatment. Here, again, the systematic arrangement is evidence of the author's methodical practice: rest, why, how long, four reasons why it "is not an unmitigated blessing"; diet; treatment of anemia; fluids, especially in sulfonamide therapy; treatment of fever; support of the circulation; oxygen therapy, five reasons for its use, three excellent illustrations of the methods advised and a tabulation of the advantages and disadvantages of each; isolation procedures, in the hospital and in the home; special reference is made to typhoid fever, etc., chlorine being recommended for disinfection without giving the concentration or amount of calcium hypochlorite necessary. Immune attendants should be secured or they should be immunized immediately.

The next four chapters contain a thoroughly up-to-date discussion of: serum therapy, sulfonamide therapy, penicillin therapy and streptomycin therapy (these two in collaboration with Hirsh). To do justice to this work, each of these sections would deserve a complete and separate review; no such exposition of every practical point concerned has been seen elsewhere.

The remaining chapters deal with the diseases themselves. These are grouped according to their responsible causative agents: diseases caused by cocci, those caused by bacilli, those in which exotoxins are a major factor; finally, miscellaneous bacterial diseases.

There is also an appendix which gives the current practical laboratory methods for: the determination of sulfonamide in blood and urine, penicillin assay (modified Rammelkamp method), and streptomycin assay. It should be noted that each chapter is followed by a list of references, citing the important contributions which one may consult if a more detailed knowledge of any point is desired. The index seems to be thorough.

Although diagnosis and treatment are claimed to be the only interests of the hospital or private practitioner served by this magnificent volume, prevention-immunization is not omitted. The paragraphs devoted to the production of active immunity are excellent and it is suggested that in future editions they be given more prominence.

Nowhere in the book has it been possible to find the admonition that communicable diseases are notifiable and should be reported to the Health Department.

1789—MEDICAL SOCIETY OF DELAWARE—1948

OFFICERS

PRESIDENT, Howard S. Riggin, Seaford

FIRST VICE-PRESIDENT, M. A. Tarumianz, Farnhurst
SECOND VICE-PRESIDENT, Henry V'P Wilson, Dover

SECRETARY, G. A. Beatty, Wilmington
TREASURER, Winfield W. Lattomus, Wilmington

COUNCILORS

Clarence J. Prickett, Smyrna (1948) Ervin L. Stambaugh, Lewes (1949) Joseph M. Messick, Wilmington (1950)

AMERICAN MEDICAL ASSOCIATION—DELEGATE: James Beebe, Lewes (1949). ALTERNATE: C. C. Neese, Wilmington (1949)

REPRESENTATIVE TO DELAWARE ACADEMY OF MEDICINE, W O. LaMotte, Wilmington

STANDING COMMITTEES

SCIENTIFIC WORK
G. A. Beatty, Wilmington
Stanley Worden, Dover
E. L. Stambaugh, Lewes

PUBLIC POLICY AND LEGISLATION
J. S. McDaniel, Dover
J. D. Niles, Townsend
Bruce Barnes, Seaford

PUBLICATION
W. E. Bird, Wilmington
M. A. Tarumianz, Farnhurst
G. A. Beatty, Wilmington

MEDICAL EDUCATION
W. G. Hume, Selbyville
R. S. Layton, Dover
J. W. Howard, Wilmington

NECROLOGY
Wm. Marshall Jr., Milford
G. W. K. Forrest, Wilmington
U. W. Hocker, Lewes

SPECIAL COMMITTEES

ADVISORY, WOMAN'S AUXILIARY
H. G. Buckmaster, Wilmington
C. C. Neese, Wilmington
J. B. Waples, Georgetown
Verna Stevens Young, Wilmington
C. C. Fooks, Milford

CANCER
V. D. Washburn, Wilmington
D. M. Gay, Wilmington
J. F. Hynes, Wilmington
J. D. Niles, Middletown
J. W. Howard, Wilmington
J. W. Spies, Dover
C. J. Prickett, Smyrna
James Beebe, Lewes
Bruce Barnes, Seaford

SOCIAL HYGIENE
D. D. Burch, Wilmington
M. B. Thompson, Rehoboth
W. H. Smith, Harrington

SPECIAL COMMITTEES

TUBERCULOSIS
L. D. Phillips, Marshallton
G. A. Beatty, Wilmington
J. M. Barsky, Wilmington
L. B. Flinn, Wilmington
J. M. Messick, Wilmington
J. S. McDaniel, Jr., Dover
C. J. Prickett, Smyrna
H. G. Hume, Selbyville
O. S. Daisey, Rehoboth

MATERNAL AND INFANT MORTALITY
A. H. Williams, Laurel
C. H. Davis, Wilmington
Margaret I. Handy, Wilmington

MENTAL HEALTH
Persis F. Elfeld, Wilmington
C. B. Scull, Dover
O. V. James, Milford

CRIMINOLOGIC INSTITUTES
E. R. Mayerberg, Wilmington
I. J. MacCollum, Wyoming
U. W. Hocker, Lewes

MED. ECON. AND PUBLIC RELATIONS
G. W. K. Forrest, Wilmington
B. M. Allen, Wilmington
I. L. Chipman, Wilmington
E. R. Mayerberg, Wilmington
W. O. LaMotte, Wilmington
J. S. McDaniel, Dover
F. R. Everett, Dover
G. M. VanValkenburgh, Georgetown
H. M. Manning, Seaford

REVISION OF BY-LAWS
W. E. Bird, Wilmington
D. D. Burch, Wilmington
C. E. Wagner, Wilmington
J. S. McDaniel, Dover
R. C. Beebe, Lewes

VOCATIONAL REHABILITATION
James Beebe, Lewes
I. M. Flinn, Wilmington
E. L. Stambaugh, Lewes
A. P. Hitchens, Wilmington
D. J. Preston, Wilmington

SPECIAL COMMITTEES

POSTWAR PLANS
M. A. Tarumianz, Wilmington
W. E. Bird, Wilmington
W. O. LaMotte, Wilmington
E. R. Mayerberg, Wilmington
J. S. McDaniel, Dover
William Marshall, Jr., Milford
J. R. Elliott, Laurel
J. B. Waples, Georgetown
R. C. Beebe, Lewes

BUDGET
M. A. Tarumianz, Wilmington
C. E. Wagner, Wilmington
J. D. Niles, Middletown
J. S. McDaniel, Dover
James Beebe, Lewes

CHEFF MEMORIAL
W. W. Lattomus, Wilmington
E. R. Miller, Wilmington
A. J. Heather, Wilmington

ADVISORY, DELAWARE STATE HEALTH AND WELFARE CENTER
L. J. Jones, Wilmington
L. B. Flinn, Wilmington
A. R. Cruchley, Middletown
I. J. MacCollum, Wyoming
E. L. Stambaugh, Lewes

RURAL MEDICAL SERVICE
J. R. Downes, Newark
T. H. Baker, Elsmere
J. D. Niles, Middletown
C. J. Prickett, Smyrna
H. W. Smith, Harrington
Bruce Barnes, Seaford
W. G. Hume, Selbyville

INDUSTRIAL HEALTH
H. L. Springer, Wilmington
J. M. Kimmick, Wilmington
L. C. McGee, Wilmington
H. V'P. Wilson, Dover
J. B. Baker, Milford
E. L. Stambaugh, Lewes
D. L. Bice, Seaford

WOMAN'S AUXILIARY

MRS. GEORGE C. MCELFATRICK, *President*, Wilmington
MRS. J. H. MULLIN, *First Vice-President*, Wilmington
MRS. W. C. DEAKYNE, *Second Vice-President*, Smyrna
MRS. G. W. M. VANVALKENBURGH, *Third Vice-President*, Georgetown
MRS. S. W. RENNIE, *Recording Secretary*, Wilmington
MRS. A. M. GEHRET, *Corresponding Secretary*, Wilmington
MRS. C. M. BANCROFT, *Treasurer*, Wilmington

NEW CASTLE COUNTY MEDICAL SOCIETY

Meets Third Tuesday

A. LEON HECK, *President*
C. L. MUNSON, *President-elect*
L. W. ANDERSON, *Vice-President*
D. D. BURCH, *Secretary*
CHARLES LEVY, *Treasurer*

Board of Directors and Nominating Committee: L. B. Flinn 1948, Ira Burns 1949, Roger Murray 1950.

Board of Censors: N. W. Voss 1948, C. L. Hudiburg 1949, C. L. Munson 1950, J. M. Messick 1951, I. M. Flinn, Jr. 1952.

Program Committee: C. L. Munson, A. L. Heck, L. W. Anderson.

Legislative Committee: L. C. McGee, F. A. Bowdle, J. R. Durham, Jr., J. A. Giles, J. C. Pierson.

Public Relations Committee: V. D. Washburn, C. T. Lawrence, Jr., M. B. Pennington, O. N. Stern, C. E. Wagner.

Medical Economics Committee: W. M. Pierson, G. A. Beatty, W. E. Bird, E. M. Bohan, E. T. O'Donnell.

Necrology Committee: Charles Maroney, I. Charamella, S. W. Rennie.

Auditing Committee: F. S. Skura, A. G. Gluckman, E. G. Laird.

Delegates (1948): D. D. Burch, Ira Burns, N. L. Cutler, J. R. Durham, Jr., J. A. Giles, A. L. Heck, J. C. Pierson, W. F. Preston, M. A. Tarumianz, R. O. Y. Warren.

Alternates (1948): G. M. Boines, Italo Charamella, D. M. Gay, L. S. Hayes, A. J. Heather, A. D. King, E. T. O'Donnell, M. B. Pennington, F. P. Rovitti, O. N. Stern.

Delegates (1949): L. W. Anderson, W. E. Bird, L. B. Flinn, G. W. K. Forrest, J. F. Hynes, L. J. Jones, E. G. Laird, L. C. McGee, Roger Murray, J. D. Niles, V. D. Washburn.

Alternates (1949): E. M. Bohan, I. M. Flinn, Jr., A. D. King, C. E. Maroney, E. T. O'Donnell, W. M. Pierson, D. J. Preston, W. T. Reardon, J. A. Shapiro, O. N. Stern, J. W. Urie.

KENT COUNTY MEDICAL SOCIETY

Meets First Wednesday

BENJAMIN F. BURTON, *President*, Dover.
S. M. D. MARSHALL, *Vice-President*, Milford.
STANLEY WORDEN, *Secretary-Treasurer*, Dover.

Delegates: I. J. MacCollum, Wm. Marshall, Jr.
Alternate: J. S. McDaniel.

DELAWARE ACADEMY OF MEDICINE

Open 10 A. M. to 5 P. M.

GERALD A. BEATTY, *President*.
B. M. ALLEN, *First Vice-President*.
ROBERT R. WIER, *Second Vice-President*.
ANDREW M. GEHRET, *Secretary*.
IRVINE M. FLINN, JR., *Treasurer*.

DELAWARE PHARMACEUTICAL SOCIETY

THOMAS N. DAVIS, *President*, Wilmington.
IRVIN WALLER, *First Vice-President*, Bridgeville.
J. G. MCNAUGHTON, *Second Vice-President*, Middletown.
H. C. HELM, *Third Vice-President*, Dover.
WALLACE WATSON, *Secretary*, Wilmington.
ALBERT DOUGHERTY, *Treasurer*, Wilmington.

MEDICAL COUNCIL OF DELAWARE

Hon. Charles S. Richards, *President*; Joseph S. McDaniel, M. D., *Secretary*; Wallace M. Johnson.

SUSSEX COUNTY MEDICAL SOCIETY

Meets Second Thursday

ROBERT S. LONG, *President*, Frankford.
JOHN W. LYNCH, *Vice-President*, Seaford.
LESLIE M. DOBSON, *Secretary-Treasurer*, Milford.

Delegates: Bruce Barnes, C. M. Moyer, J. B. Homan, A. H. Williams.
Alternatess V. A. Hudson, J. L. Fox. G. W. M. VanValkenburgh, E. L. Stambaugh.

DELAWARE STATE DENTAL SOCIETY

JAMES KRYGIER, *President*, Dover.
R. R. WIER, *First V. P.*, Wilmington.
C. W. JOHNSON, *Second V. P.*, Wilmington.
G. A. ZURKOW, *Secretary*, Wilmington.
H. H. MCALLISTER, *Treasurer*, Wilmington.
P. A. TRAYNOR, *Delegate A.D.A.*, Wilm.

DELAWARE STATE BOARD OF HEALTH

J. D. Niles, M. D., *President*, Middletown; Mrs. F. G. Tallman, *Vice Pres.*, Wilmington; W. B. Atkins, D. D. S., *Secretary*, Millsboro; Bruce Barnes, M. D., Seaford; Mrs. C. M. Dillon, Wilmington; J. B. Baker, M. D., Milford; Mrs. Alden Keane, Middletown; E. R. Mayerberg, M. D., Wilmington. Edwin Cameron, M. D., *Executive Secretary*, Dover.

BOARD OF MEDICAL EXAMINERS

J. S. McDaniel, *President-Secretary*; Wm. Marshall, *Assistant Secretary*; W. E. Bird, J. E. Marvil, L. J. Jones.